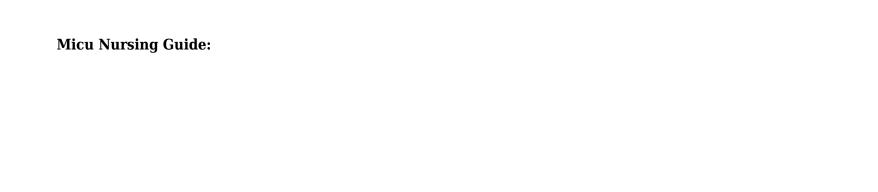
| Assessment | Nursing Diagnosis | Planning | | | | The state of the state of |
|---|--|--|--|---|--|--|
| | | Objective of Care | Intervention | Rationale | Implementation | Evaluation |
| Subjective cues The SO verbulcand "Manus Aumingal Anti-may planes." Objective cues Restess Dyspecs Bit: 154/87 mening RR: 27 besubstrate PR: 97 bpes OZuat: 97% | Ineffective airway clearance related to retained secretions as evidenced by dyspecis, alteration in respiratory rate and restless | After 10hrs of Nursing intervention, the client will be able to; • Malestale pirvay patiency | Position bead appropriately for age and condition. | To open or maintain open sirvey in an at-rest or compromised individual. | Positioned the client according to ber condition. | airway in evidenced by vital signs; o RR - 19bpm o O2sas 97% • Expectorate secretions upon sucriceling with appropriate cathence. • Demonstrate behaviors of clear sirvay in |
| | | | Monitor respirations and breath sounds, noting rate and sounds (e.g., tackypnes, saridor, crackles, or wheepes). | Indicative of respiratory distress and/or accumulation of secretions. | Noted client erupirations, breath sounds and rate. | |
| | | Expectorstolchear secretions readily. | Section rose, mouth, and arachea pre- using correct-size catherer and section timing for adult. | To clear sirvey when excessive or viscous secretions are blocking airway or client is unable to swallow or cough effectively. | Assisted in sucrioning and used appropriate cuthems. | |
| | | | Exercise diligence in providing onli hygiene and keeping seal mucosa hydrated. | Airways can be obstructed by substances such as blood or thickened secretions. These can be rearraged by series attention to good oral hygiene, especially on the client who is seable to provide that for self. | Provided client with and hygiene and kept and mucosa hydrated after section. | |

Micu Nursing Guide

SJ Ball



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